ON THE

ETIOLOGY OF VAGINAL HÆMATOMA OCCURRING DURING LABOUR.

BY

J. HALLIDAY CROOM, M.D., F.R.C.P.E., F.R.S.E.,

PHYSICIAN TO THE ROYAL MATERNITY HOSPITAL; PHYSICIAN FOR DISEASES OF WOMEN, ROYAL INFIRMARY; LECTURER ON MIDWIFERY AND DISEASES OF WOMEN, EDINBURGH.

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SANGUINEOUS tumours, thrombi and hæmatoma of the vulva and vagina, whether occurring before, during, or after labour, are comparatively rare accidents. Under such a heading are included all collections of blood forming in the submucous or connective tissue, and they may be found in the cervix, any part of the vagina, labia, or perimetric connective tissue. The condition receives more or less attention in every text-book, and the varieties, with their progress, terminations, and treatment, have been exhaustively discussed, in lengthened memoirs, by Deneux, Laborie, Cazeaux, Hervieux, Hugenberger, and Barnes, and have received shorter notice from many others. Into the general question of the nature and management of these hæmorrhages in general it is no part of my present paper to enter. I wish, therefore, to eliminate, first, the blood extravasations which are limited to the cervix, and which in a minor form are familiar to most of us. In an aggravated and serious form they are at times associated with elongation and hypertrophy. This much I wish to point out, that they are the result of direct pressure and crushing. Second, Those which form in the labia vulvæ, and which are the result of unusual pressure applied to already distended and varicose vessels.

My remarks apply entirely to that form of hæmatoma which is vaginal, usually confined to the posterior wall, and is developed during and after labour. Three such cases have come under my observation, and I now give a brief record of each.

CASE I. occurred in the hands of one of my dispensary pupils. Mrs M., a multipara in labour with her sixth child. When I saw her the membranes had ruptured for twelve hours, and the head had made no progress though the pains had been strong. On examination I found the head at the brim and moveable; os fully dilated. The cause of delay was obvious. The woman's lax abdominal walls had allowed the uterus to become anteverted, —so much so, that the fundus uteri was on a level lower than

the cervix, and consequently the uterine action was quite unavailing so long as the direction of the force was thus misdirected. I ordered the patient to have a tight abdominal bandage applied, and to have a full dose of ergot. Two hours afterwards the child was born. Next day I was asked by my pupil to see the woman, who complained of great bearing down pains, and something protruding at her vulva. On examination I found the perinæum bulging, and a dark swelling protruding from the vagina. I found the whole vagina filled by a large pyriform mass, base downwards, stretching from the posterior fornix down to the perinæum.

She suffered much pain during the night, with strong expulsive efforts; and when she was seen in the morning, a rupture had taken place at the lower end of the vagina, through which had escaped free venous blood and clots. There continued considerable oozing from the aperture for a fortnight, during which time careful antiseptic washing was employed; and at the end of three weeks the tumour had entirely disappeared.

CASE. II. occurred in the extern department of the Maternity Hospital. The patient was a multipara in labour with her fourth child. As the patient had been in labour for ten hours, as the membranes had been ruptured for six, and as no progress was made, I was called to see the case and deliver with forceps. I found the pains very violent and strong; the head presenting, but not engaged in the brim. The uterus was markedly anteverted, the patient being a big, heavy woman, with a very pendulous belly. The uterine body was thrown well forwards, and somewhat flexed. The delay was evidently caused by the misdirection of the uterine force. I placed the woman on her back, and had a binder applied.

On introducing my hand, some fifteen or twenty minutes later, into the vagina, I felt a distinct bulging in the fundus vaginæ in the posterior fornix. The nature of this I did not at the time recognise. As the head was moveable at the brim, and did not engage even after the position of the uterus was rectified, I performed podalic version. I found a little difficulty in extracting the head from the vagina. With the last pains the placenta and membranes were expelled *en masse*. As violent expulsive efforts continued, and as she complained of great pain, and although there was no hæmorrhage beyond normal, she looked somewhat collapsed, I made a vaginal examination, and found a large tumour bulging the posterior vaginal wall. It extended in a conical shape, the base being at the vulva and the apex at the cervix. Next morning when I saw the patient I found she had passed a restless night. There was pelvic pain, bearing down expulsive efforts, and retention of urine. On examination the vagina was so occluded that I could not reach the cervix. The

conical nature of the tumour, its intimate connexion with the mucous membrane, its firmness and tenderness, as well as the fact that it reached quite down to and bulged the perinæum, combined with a rectal exploration, decided me in coming to the conclusion that it was a hæmatoma of the vagina. Rest, quiet, and opium were enjoined. The next day she was free from pain. There was no rupture of any part of the tumour. In four or five weeks the patient was well, and no trace of the tumour remained.

CASE III.—Through the kindness of Dr Alex. Sinclair, I saw with him a patient whom he had delivered two or three days previously with forceps. She was a multipara with her fifth child. Dr Sinclair had used forceps because the head was delayed high up, owing to some degree of anteversion of the uterus. The patient had borne her previous children normally. Dr Sinclair told me that when applying his forceps he felt a swelling in the posterior fornix, and on that account experienced some difficulty in applying the instrument.

The swelling on the third day was so large as to fill up the whole vagina, and so closed the canal as to make it impossible to reach the cervix. The perinæum was bulging, and at the junction of the perineal skin with the vaginal mucous membrane there was a rupture which had occurred the previous day, when Dr Sinclair was examining the tumour. The aperture was sufficiently large to admit two fingers, and on doing so the finger came in contact with a mesh-work of cellular tissue and clots. The nature of the tumour was clearly that of a hæmatoma. I need not stop to describe its further course beyond saying, that the cavity was washed out daily with an antiseptic lotion, the patient had no bad symptoms, and in a few weeks was quite well.

The rarity of such cases may be gathered from the following statistics, viz.,—Hugenberger, St Petersburg Hospital, met 11 in 14,000 labours. Deneux saw 3 in forty years. Paul Dubois 1 in 14,000 labours. In Vienna Hospital 18 occurred in 33,241 deliveries.

The records show that these extravasations are associated with very considerable danger. Deneux out of his 60 cases had a mortality of 11. Probably it is owing to this fact, Deneux being the earliest writer on the subject, that the opinion has gained firm ground that this condition is an extremely dangerous one. Now, this is scarcely the fact, for out of 50 cases collected by Winckel, death occurred only six times ; and the three cases which I had just mentioned all recovered perfectly, and one had a normal labour subsequently. No doubt a good deal depends on their extent and situation, but so long as they are confined either to the vulva or vagina, remain of moderate dimensions, and do not

begin in or extend to the perimetric tissue, they seem to be less serious than was at one time supposed. My present object is to point out what I believe to be the etiology of this form of vaginal hæmatoma, or, at all events, *one* of the causes. In whatever respects the cases I have recorded may differ, they had the following points in common:—*1st*, The women were multiparæ; *2nd*, The labour was delayed; *3rd*, The cause of delay was misdirection of the uterine power from anteversio uteri or pendulous belly; *4th*, At the occurrence of the hæmatoma the head was still at the brim.

First, then, there is the common feature of pendulous belly. This, of course, when not associated with narrow brim, as it sometimes is in primipara, means anteversion of the gravid uterus from relaxation of the abdominal walls.

This is a question of degree so slight that the contraction of the uterus may be sufficient to remedy the displacements, or to such a marked degree that the fundus uteri comes to lie on a level lower than the cervix. Fig. 1 shows the varying degrees of pendulous belly, from slight inclination of the fundus forwards to that where the fundus lies on a level lower than the cervix.

Nay, more, cases have even been related where, owing to a split in the recti muscles, the gravid uterus has prolapsed through the aperture and reached almost to the knees, covered only by skin and fascia. In even moderate cases there is a certain amount of flexion as well, the under part of anterior wall of the uterus being bent over the anterior wall of the pelvis, the symphysis pubis acting as a fixed point (Fig. 2). In this way tension is made to a very marked degree on the vaginal walls. This tension is produced by two factors,—*1st*, The tilting forward of the uterus over the symphysis—this, of course, being in direct proportion to the amount of anteversion; *2nd*, By the uterine pains. They will, by drawing on the posterior vaginal wall, increase the tension already caused by the altered position of the uterus. (This condition is shown in Fig. 2.) It will be apparent, and it is a fact borne out by clinical observation, that the symphysis pubis acting as a fixed point, the greatest tension and stretching will be on the posterior vaginal wall. In an interesting and suggestive paper read to this Society some years ago by Dr Hart on Rupture of the Vagina, he drew attention to two facts bearing on the present subject,—*1st*, That vaginal rupture is generally high up on the posterior vaginal wall; and *2nd*, When it does occur, it is generally transverse. The posterior vaginal wall, especially at its upper part is, during pregnancy, very thin. This thinning is increased in a normal labour by the uterine action dragging up the cervix and vaginal walls; but in the cases I have just referred to, there is the very great additional stretching in-

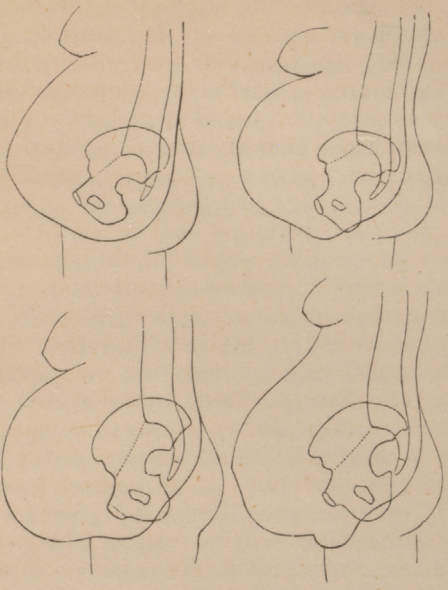

FIG. 1.

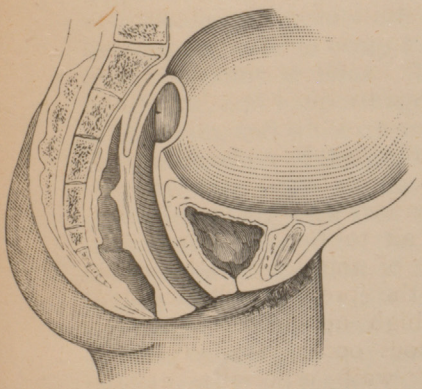

FIG. 2.

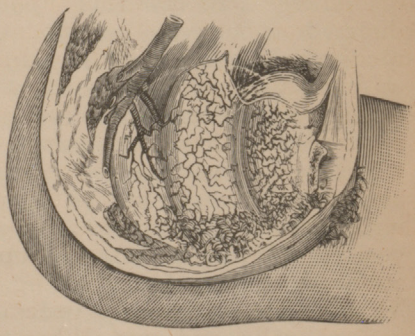

FIG. 3.

duced by the abnormal position of the uterus, and the long-continued ineffectual contraction of the uterine walls. The venous supply to the vaginal wall consists of a large plexus of veins, some submucous and some just outside the muscular coat, emptying themselves into the internal iliac. These veins, in common with the other veins in the pelvis, are valveless. Fig. 3, after Savage, gives some idea of the number and close distribution of these veins. In pregnancy these veins, to a greater or less extent, become varicose, owing, no doubt, to the heavy uterus preventing the entrance of the venous blood to the vena cava. So uniformly is this varicosity present, that, under the name of Jacquemier's test, it has come to be recognised among the corroborative signs of pregnancy. Often the venous tissues become so distended with varicose enlargement that they become quite perceptible to the finger in the vagina, and can be felt projecting as well-marked cyst-like swellings. Further, it must be borne in mind that, in proportion to the amount of varicosity, so will the wall of the vessel be thin. Hervieux, Laborie, and others are not inclined to believe that varix enters much into the production of these vascular swellings. Perret has collected a series of sanguineous tumours of the vagina, cervix, and vulva, and points out that they occur more frequently by five times in primiparæ than multiparæ, and that they become proportionately rarer according to the number of the pregnancy. Now, in this record Perret mixed up all the varieties. One can easily understand how, under the enormous distending pressure on the cervix and vagina caused by the advancing head, the mucous membrane, carried down by the head, glides over the deeper tissues with a sort of tearing movement. The connecting submucous vessels are torn, blood is extravasated, and small ecchymoses or thrombi are formed. This will to a greater or less extent occur in every labour. But we must not be diverted from the point at issue. The cases I have recorded were all multiparæ, and hæmorrhage took place while the head was still at the brim, and while no pressure was being made in the vagina. The mechanism of the production seems to me to be this,—The thin varicose veins on the posterior vaginal wall all undergo stretching along with that structure by the uterine efforts ; but, in the cases referred to, the tension is enormously increased by the anteverted position of the uterus ; and further, this tension is long maintained by the ineffectual attempts of the uterus to right itself. What occurs is this : during the labour one or more of these vessels give way under the strain, and rupture, but owing to the tension no hæmorrhage takes place. When, however, the case is recognised, and the uterine obliquity overcome, either by position or pressure, or both, the undue tension of the posterior vagina relaxed, the compression of the vessels removed, the hæmorrhage slowly and gradually takes place into the con-

nective tissue. In this way it comes about that the rupture of the vessels takes place during the labour, but that the hæmorrhage actually occurs only after the displacement of the gravid uterus has been rectified. Into the prognosis, course, symptoms, and risks of these varieties of tumours it would be altogether absurd in me to enter; they are well described in every text-book. My object is simply to draw attention to a hitherto undescribed cause of their production, and if I may draw a practical lesson, I would add this as one of the risks of labour complicated with a pendulous belly, and an additional reason for recognising and rectifying this form of dystocia early.

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INTRODUCTORY ADDRESS.

Our Society to-night enters on the forty-eighth year of its existence, and in opening a new session my first duty is to thank you for the honour you conferred on me a year ago in elevating me to the post I now occupy as your President. I am keenly sensible of the responsibility I have incurred in accepting such a trust from your hands, realizing as I do the high honour which it carries with it, and my own unworthiness to follow the distinguished men who have preceded me in this Chair. I am glad to congratulate you on the continued prosperity of our Society. From small beginnings it has now risen to a membership of 260, and is producing yearly almost as large a volume of Transactions as the Medico-Chirurgical Society, which has the two great departments of Medicine to draw from. Our financial condition continues alike to give satisfaction to and reflect credit on him who has so long and so successfully presided over our exchequer.

The past year has been fruitful in the production of much good work. The session was opened by a most interesting and exhaustive discussion, introduced by Dr Barbour, on the relation of micro-organisms and puerperal fever. We were indebted to Dr Symington for an elaborate and instructive anatomical paper on the uterus in the child. Dr Milne Murray made a very valuable addition to gynæcological literature by his series of careful experimental investigations on the action of water at different temperatures, in which he established, on a scientific basis, a clinical fact with which we had been familiar. Dr Berry Hart, with his usual ability, contributed a paper on the much-vexed question of rotation of the fœtal head. We have, as a Society and as a School, to thank Professor Simpson for his important communication on obstetrical nomenclature, which, if adopted, will do much to simplify the study and teaching of Obstetrics. Among the other papers of special interest were those of Dr Ballantyne on sphygmographic tracings in labour,—a paper which reflected much credit on one of our younger Fellows. Dr Skene Keith, in addition to the exhibition of many pathological specimens, contributed several

papers full of clinical interest; while Dr Felkin, at the close of the session, gave us, as a result of his African travel, a suggestion on the determination of sex.

But amid the much that this new session brings of congratulation on the work done in the past, and of consequent hope for the future, we cannot but feel that we shall begin another winter's labour with many vacant places round our table, and with a roll of members thinned, as in no previous years so sadly or to such an extent, by death. Since I assumed the duties of this Chair, just a year ago, no less than ten of our members have been taken from us. We shall miss from our daily professional life the faces of such veterans as Cumming, Dunsmure, Finlay, Gordon, Williamson, and Pridie. They had reached the full term of mortal life, and after "bearing the burden and heat of the day," have earned an honourable rest. Of Macdonald, called from us too soon in the midst of his days and his usefulness, I have already been privileged to speak. Close on his death followed that of Sidey—he, too, in the throng of his active work. Younger than he, though he had indeed reached middle life, my old school-fellow Moinet has been taken from us. And, lastly, death, which has "all seasons for its own," and heeds neither age nor usefulness, has removed from the roll of our Society Fred Jelly, among the youngest of our Fellows and a favourite pupil of my own, leaving behind him the precious memory of a blameless life. It is for us

"To fill up the gaps in our files,
Strengthen the wavering line,
To stablish, continue our march
On to the bound of the waste,
On to the city of God."

The question which has been most prominently brought before those interested specially in gynæcology during the past year has been the removal of the uterine appendages for various forms of disease. The subject has been discussed at all the various societies. It has been the theme of much acrimonious and personal rancour. It has even penetrated into our courts of justice. It is a question of deep and abiding interest to us as gynæcologists. If it confers on the suffering woman the benefits which its advocates claim for it, then it is a triumph of abdominal surgery, second only to ovariotomy itself. If it does not, then those who advocate it have opened up a surgical operation which either in the hands of unscrupulous men, or men of feeble judgment, gives the utmost latitude for the practice of a most questionable form of gynæcology.

The removal of the uterine appendages, when affected by minor forms of disease, is one of the easiest operations in surgery, and like all easy operations for the removal of important structures, requires to be hedged about with the utmost care. The fact that this operation can be and is performed daily, and with success too,

by men who have not been specially trained in surgery, is of itself a proof, if any were wanting, of the comparative ease of the operation. Further, when we consider that the operation involves the removal of organs which are, so to say, "the pivot on which the human race turns," and which, therefore, when once removed deprive the woman entirely of the privilege of maternity; when we further consider the uncertainty in many cases of condemning them as being incapable of fulfilling their physiological functions; and if regard be had to the fact that the ordinary woman can but imperfectly understand the true import of their removal, then, I think, we establish good ground for making clear the indications for the operation.

It seems to me that as a Society we should try to formulate an opinion on a subject of such importance. I am well aware that it will be said of this operation, as of all other operative procedures, that it suffers at present from comparative novelty, and that every operation is at first done to death. Perhaps no better example can be adduced than that of Emmet's operation, which is amongst the latest illustration of the kind. I venture to believe that this operation, within the last few years, is not performed more than half as often as it used to be.

What, then, are the conditions under which removal of the uterine appendages ought to be undertaken? In employing the term *removal of appendages*, I am using that which Mr Lawson Tait—to whom belongs the credit of introducing and popularizing the operation—has applied, in preference to castration, oophorectomy, and so forth, to these cases where the ovaries and tubes are removed, except where they are the seats of large tumours. Under what circumstances, then, is this operation justifiable? The first class of cases where the operation comes under consideration is when it is performed with a view of checking uterine hæmorrhage, whether that be from a rapidly growing bleeding fibroid, or from a soft bleeding uterus.

In such cases the principle of the operation is the induction of cessation of menstruation and the production of retrogressive changes in the tumour. Naturally, the question of cause of menstruation suggests itself. Does it depend on tubes or ovaries, or both, or neither? This, however, I am not concerned to discuss. There can scarcely be a doubt, from a large body of accumulated experience, that in the majority of cases the complete removal of the ovaries and tubes, so far as it is possible to remove the tubes completely, arrests uterine hæmorrhage, and modifies, to say the least, a fibroid growth. I admit that this is not invariable, for I have myself seen cases where the hæmorrhage has continued for at least two years after the removal of the ovaries and tubes. On the whole, however, the general consensus of opinion is in favour of this operation in the case of rapidly growing fibroid. The earlier the necessity for this operation is recognised the better will the results

become, for once it is acknowledged that the removal of the ovaries and tubes checks the growth of the tumour, the sooner will the hazardous operation of hysterectomy become obsolete. Here, again, however, owing to the frequency of fibroid tumours, the operation is liable to be overdone to almost any extent, and the line must be definitely drawn at those tumours which are rapid in their growth, or which threaten life and health by hæmorrhage. Within what dimensions we can hope to remove the appendages with safety is an open question. Sometimes even in small tumours, owing to the splitting and shortening of the broad ligament, there is difficulty experienced in bringing the appendages to the surface. In any case where the tumour has reached the size of a five months' pregnancy the limits of safe removal will probably have been attained.

Again, with regard to that class of cases where the appendages are the seat of purulent or hæmorrhagic collections, the indication for their removal is obvious. The principle here involved, however, differs entirely from the cases previously alluded to, for in the latter variety it is simply dealing with a purulent collection in a tube, involving, it may be, only the removal of the tube on one side, not even of the corresponding ovary. In my opinion, the diagnosis of such condition is by no means easy. A study of the pulse and temperature, a careful bi-manual examination, if need be under chloroform, is essential for their recognition; for I hold it is our bounden duty to make our diagnosis as accurate as possible before operation. We are told by those who go in most largely for these operations, that a bi-manual is, first, useless, and secondly, dangerous. But why useless? If we grant an accurate —so far as that is attainable—diagnosis essential, I am not aware that there is any method short of a careful bi-manual which reveals to us the exact relation and condition of the parts within the pelvic cavity. Even with a very carefully conducted bi-manual, the task is sometimes difficult enough; but without it diagnosis must degenerate into a mere guess. As a school we have done our best to inculcate this doctrine; and I, for one, still believe that accurate diagnosis is a consummation devoutly to be wished for in every case before resort is had to the knife. This is so in every other branch of medicine and surgery; why should pelvic surgery be an exception?

But it is averred that the bi-manual is dangerous in these cases. Again, I ask why? If it be kept in view, as is always taught, that the lighter the touch the more thorough will be the appreciation of the sense, what harm can come of it? The answer is, that by handling the organs in this way you may rupture a tube, swollen either with pus or blood, and extravasate the contents into the pelvic cavity. Here let me quote the words of Emmet, speaking of the method of making vaginal examinations,—"It is, indeed, remarkable what a difference in this respect exists be-

tween individuals. One will undertake the examination with as much vigour as he would use were he to bore a hole into a pump-log, and is sensible to little more than the cervix, which feels like an obstruction in his way. He will gain no information of importance, and will inflict needless pain on the patient. Another, in less time, will pass his fingers lightly over every portion of the vagina and quickly gain information to enable him to fully understand the case without having caused any pain. The manner," Emmet continues, "in which I have sometimes seen this examination conducted, even by men of experience, could only be described as brutal, in consequence of the needless amount of suffering inflicted, evincing a want of tact sufficient to debar him from the practice of any other branch of the profession."

So far as my comparatively small experience is concerned, there is no class of cases in which the operation is more clearly indicated, and where the benefits are so unquestionable, as those where the ovaries and tubes have become the seat of gonorrhœal infection, and where the classic symptoms and signs of tubal disease are well marked.

When the sterility and dysmenorrhœa are incurable, when the pelvic pain and distress are constant, and when the patient runs an ever recurring risk of dangerous and even fatal inflammation being lit up on comparatively slight provocation,—in such cases it seems to me that removal of the diseased organs is sanctioned by the strongest prudential motives.

It is, however, in inflammation or inflammatory deposits in or around the tube or ovaries that the difficulty lies in laying down some definite line of practice. In a case where, after a labour or an abortion, the patient has suffered from severe or neglected inflammation, where the ovaries and tubes are matted together into one indistinguishable mass, where the patient, as a matter of course, is sterile, where the menstrual pain and general pelvic discomfort are pronounced, and where the condition has resisted all the ordinary forms of treatment, removal of the appendages comes to be a question, *not* of *urgency* as in the fibroid cases, *not* of *necessity* as in the pyosalpinx, *not* as a matter of *safety* as in the gonorrhœal cases, but simply and solely as a matter of increased comfort to the patient. Hence, therefore, as comfort is merely a relative term, it is of the utmost consequence that any operation undertaken to relieve a disease which neither of itself causes death nor shortens life, should be guarded round with every care. All of us know, from past hospital, dispensary, and private practice, that there are hosts of women who are the subjects of inflammatory deposits, adhesions the result of abortion, hæmatocele, and so forth, who in the humbler class of life perform their domestic duties with but little complaint—perhaps to them even their acquired sterility is something of an advantage—while to others in the better classes the condition is one of continuous complaint. To this latter, removal of the ovaries

does not repair their over-strained nervous system, nor, of course, does it bring them a pregnancy. In neither case is the operation strongly indicated. Its results, though often satisfactory, are by no means uniform, and hence the operation is to be undertaken only after the most careful consideration. There are, however, a set of so-called inflammatory cases at which I think some line should be drawn. Let me give a clinical picture of what I mean, and of what must be familiar to you all. A woman, generally young and in comparatively good health but for her pelvic discomfort and, perhaps, her sterility. On inquiry, she has some premenstrual pain, painful coitus, and her menstruation is rather profuse. On local examination the ovary or ovaries are felt enlarged, tender, and probably prolapsed. On careful bi-manual examination the tubes are palpated, and felt thick and enlarged. The diagnosis is subacute inflammation of the tubes and ovaries. On listening to the records of abdominal sections one hears of numbers of such cases which have been operated on. Here I for one draw the line. There is no reason to suppose that inflammation of the ovaries and tubes should not respond to appropriate treatment—on the contrary, there is every reason to believe it does—any more than that of other organs in the body.

There is no reason why a woman should be deprived of her ovaries because they are chronically inflamed any more than a man should be deprived of his testicles because there is some thickening of the tunica vaginalis as a result of orchitis or some neuralgia of the cord, or because he is the subject of well-marked varicocele. Women affected in this way are often, I admit, but by no means invariably sterile. I can at this moment point to two women who for years were sterile, and presented the symptoms which I have just instanced, and have since borne children.

The unvarying reply given by those who advocate these operations is that the women themselves must be the judges as to whether the operation ought or ought not to be performed. Why so? In a case of growing fibroid I say the ovaries *must* be removed, in order to avoid a more dangerous operation later on. In a case of pyosalpinx removal of the suppurating mass is a necessity. In a case of gonorrhœal infection the organs are useless, the suffering is great, and the risk of dangerous inflammation is constant. Even in a case of simple inflammation and fixation there is a good deal to be said in favour of operation, but in those cases which I have mentioned last, where the ovaries and tubes are movable, the operation, if undertaken at all, is an extremely questionable one, and for the following reasons:—1st, Because it is impossible in such cases to say that the organs are organically diseased. 2nd, Because pain and pelvic distress are such movable quantities. 3rd, Because in the majority of cases the symptoms complained of can be, to say the least of it, ameliorated by less severe remedies. Lastly, Because an hysterical element so

often enters largely into these cases, which operative interference very slightly, if at all, removes.

It has been urged that numbers of those women who suffer in the way I have just mentioned belong to the working class, in whom measures so essential to relief, viz., rest—physical, mental, and, above all, sexual—along with local treatment, such as hot-water, blisters, etc., are unattainable. Yet I question if the long and absolute rest required after an abdominal section extending over many weeks would not be as beneficially employed in rest and treatment without the operation. That a condition of hysteria or neurasthenia, acquired or otherwise, enters largely as a factor into many of these cases must, I think, be admitted by most of us. This, I am confident, requires to be treated as well and as much as the local removal of the organs at fault.

The treatment, I venture to believe, advocated by Erb, Weir Mitchell, and Playfair, might in many cases be carried out as a substitute for some, and an adjunct in many cases of removal of the uterine appendages for inflammatory conditions.

It is certain, at any rate, that the cases of removal of the uterine appendages into which any element of hysteria enters are the least successful in their ultimate results. The question as to the removal of these organs for reflex and mental conditions, epilepsy, etc., is one into which my own want of experience prevents me presuming to enter. I feel sure that we require much more evidence than we at present possess for sanctioning the performance of an operation in such debatable ground, and I am confident, in this school at least, that the adoption of this operation will be received with the caution characteristic of our country.

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